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ABSTRACT

This monograph examined the concept of full-service schools and considers how students with disabilities may interface with them and ultimately benefit. Full-service schools have been described as a one-stop center at which educational, physical, psychological, and social requirements of students and their families are addressed in a coordinated, collaborative manner using school and community services and supports. The report is organized around the following five questions: (1) "Why full-service schools?" (the need); (2) "What is a full-service school?" (schools house a variety of services for children and their families); (3) "What is the relationship of full-service schools to special education?"(full-service schools and special education and special education and comprehensive services) (4) "What are special education researchers learning about full-service schools in California, Maryland, and Florida?" (California's Healthy Start program, the University of Maryland's Linkages to Learning model and the University of Miami's research on Florida's statewide Full Service School program); and (5) "What are policy and practice implications?" (full-service schools offer promise in prevention, early intervention, supporting students with multiple risk factors, and providing comprehensive intervention support). (Contains 39 references.) (DB)

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September 2002

Full-Service Schools' Potential for Special Education

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Full-Service Schools' Potential for Special Education

In order to benefit from school, a large number of children with risk characteristics—and their families—require health, social services, and other supports. In some cases, children may have multiple and/or complex needs that require comprehensive approaches that effectively link the school, home, and community. This is particularly true for children with disabilities, whose families often have disproportionately more needs than families in the general population (Newman, 1997).

One relatively new approach that shows promise for addressing the complex needs of children and their families is full-service schools. During the early 1990s, the concept of full-service schools gained momentum in education and social reform movements as a promising approach for providing integrated, comprehensive, and intensive services to children and their families. Full-service schools have been described as a one-stop center at which educational, physical, psychological, and social requirements of students and their families are addressed in a coordinated, collaborative manner using school and community services and supports (Dryfoos, 1994).

Children's learning directly benefits from adequate social services and suffers when such services are not forthcoming. If the schools are to be held accountable for students' academic achievement and preparation for the workplace, they have a vested interest in other factors that impact learning.— National School Boards Association, 1991

For the most part, full-service school programs heretofore have been designed for at-risk children—with programs spanning different levels of intervention including prevention, early after-onset intervention, and treatment for severe and chronic problems. While students with disabilities may access these services, the potential of this approach for them is only beginning to become apparent.

This ERIC/OSEP Topical Brief examines the concept of full-service schools and considers how students with disabilities may interface with them and ultimately benefit. To this end, the topical brief answers the following questions:

- Why full-service schools?
- What is a full-service school?
- What is the relationship of full-service schools to special education?
- What are special education researchers learning about full-service schools in California, Maryland, and Florida?
- What are policy and practice implications?

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Why Full-Service Schools: Addressing the Need

Increasingly, children are coming to school with a myriad of risk characteristics that interfere with or impede their learning. For the 70.2 million children under the age of 18 living in the United States, consider the following statistics (Federal Interagency Forum on Child and Family Statistics, 2000):

- 18 percent of children live below the poverty level. For African American children, the rate is 36 percent and for Hispanic children, the rate is 34 percent.
- 19 percent are considered to be in poor overall health.
- The infant mortality rate for every 1,000 live births is 7.2. For African Americans, the rate is 13.7.
- The pregnancy rate is 30.4 for every 1,000 females between the ages of 15 and 17. For African American teens, the rate is 56.8 (per thousand) and for Hispanic teens, the rate is 62.3 (per thousand).
- Youth between the ages of 12 to 17 committed more than 616,000 serious violent crimes (e.g., homicide, rape, robbery, aggravated assault) in 1998. Among youth aged 18-19, the rate of firearm deaths is 27 per 100,000.

Children with disabilities may be even more at risk, given that they are disproportionately poor, more likely to live in single-parent families, more likely to live in families whose heads of household are not high school graduates, and more likely to be victims of abuse or neglect in comparison to children in the general population.

(Crosse, Kaye, & Ratnofsky, 1993; Wagner et al., 1993)

Persistent, often severe and enduring stressors are the backdrop from which serious emotional disturbances can arise, distracting children from their schoolwork and impeding their abilities to learn (Fox, Rubin, & Leone, 1994). Children with disabilities may be even more at risk, given that they are disproportionately poor, more likely to live in single-parent families, more likely to live in families whose head of household is not a high school graduate, and more likely to be victims of abuse or neglect in comparison to children in the general population (Crosse, Kaye, & Ratnofsky, 1993; Wagner et al., 1993).

Educators have long known that children who are hungry and undernourished, who fear for their safety in neighborhoods and homes, or who have unmet health or mental health needs will find it difficult to devote 100 percent of their attention to classroom learning. Without intervention, many of these children will develop educational and other difficulties that may negatively affect their long-term outcomes for later school and post-school success.

The provision of integrated services within school settings represents a promising trend that has the potential for helping students stay in school, where they are afforded the opportunity to learn to high standards (Wagner et al., 1994). Consider just a few of the positive results found in research studies:

- Students in a full-service school gained access to services—particularly mental health services—faster than to those same services through special education. Moreover, brief treatments often successfully addressed the presenting problem, which served to avoid more intensive services, such as special education (Flaherty, Weist, & Warner, 1996).
- Students who required and received mental health services during the academic year showed significant declines in depression and improvements in self-concept from pre- to post-intervention (Weist, Paskewitz, & Warner, 1996).
- In schools with school-based health clinics, fewer students reported considering suicide compared to national statistics (Kisker & Brown, 1996).
- Teenagers in schools with school-based health clinics had fewer pregnancies (Zabin et al., 1986).
- Clinic users were absent from school less than other students (McCord et al., 1993). This may be due to the fact that when students require services outside the school setting, it is typically the responsibility of the student and family to set up appointments. Agencies may schedule appointments during the school day, causing students to miss school. Students lose less time from their studies when they stay in school for services.

The available data suggest that full-service schools have the potential to promote a better interface of school and human service systems, increase service use, and positively affect developmental outcomes for children living in high-risk situations.

The available data suggest that full-service schools have the potential to promote a better interface of school and human service systems, increase service use, and positively affect developmental outcomes for children living in high-risk situations (Adelman & Taylor, 1997; McMahon et al., 1999; Zigler et al., 1997). From a prevention perspective, full-service schools hold promise for reducing the escalation of problems in severity and intensity, as school personnel—who see students on a daily basis—have direct access to help when they need it. In addition, full-service schools may offer the potential for delivery of more intensive, integrated services to special education students in a natural and accessible setting—the neighborhood school.

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What is a Full-Service School?

Full-service schools represent an effort to make human service systems partners in the educational process, while simultaneously making school systems partners in the delivery of human services. (Adelman & Taylor, 1999). Full-service schools are one model of school-linked services. In this model, schools house a variety of health, mental health, and other services for children and their families.

Housing services on school grounds alleviates many of the problems that interfere with families obtaining services for their children (e.g., no transportation, lack of understanding in how to navigate the public health and social service systems, inability to take time away from work, and no health insurance). While the type of services offered by full-service schools vary—with programs, spanning different levels of intervention including prevention, early after-onset intervention, and treatment for severe and chronic problems—they hold in common the delivery of services on or near the school grounds. [FIGURE 1 presents examples of services.] Services are provided to children and their families through a collaboration between the school, agencies, and the families. Schools are among the central participants in planning and governing service design and delivery.

A full-service school is a school that has broadened its mission and vision to meet the needs of all of its students by providing integrated services—health, mental health, social and/or human services, and other services—that are beneficial to meeting the needs of children and their families on school grounds or in locations that are easily accessible. Full-service schools also provide the types of prevention, treatment, and support services children and families need to succeed, including education, health care, transportation, job training, child care, housing, employment, and social services (Dryfoos, 1994). By meeting the noncurricular needs of children and families, the full-service school helps to ensure that learning will happen for all students in the school (Kronick, 2000).

In short, full-service schools encompass both quality education and comprehensive, integrated support services. Integration does not typically mean the merger of these service systems but rather increased collaboration among them. School, agency, community personnel, and families have common and shared goals and participate in joint decision making. Partners design comprehensive strategies to bring together a range of resources to strengthen families and promote the healthy physical, social, emotional, and cognitive development of children. Figure 2 presents a summary of key features found in full-service schools.

FIGURE 1. Types of Services

Prevention	Early after-onset intervention	Intensive treatments for severe/chronic problems
• Adult education • Immunizations • Family planning • Recreation • After-school care • Social service to access basic living resources • Economic services/job placement • Quality early childhood education • Mental health and physical health screening • Consultation • Drug and alcohol prevention • Drop-out prevention • School meal programs • Child care	• Guidance and counseling • Gang diversion programs • Tutoring • ESL and citizenship classes • Public health care • Conflict resolution • Prenatal care and well-baby care • Child abuse education • Juvenile alternative services • Latch-key services • Mental health counseling	• Special education services • Related services • Emergency, crisis treatment • Case management

The Relationship of Full-Service Schools to Special Education

While there has been some research on the effectiveness of school-linked services in general and full-service schools in particular for the general population, little is known about these models and special education (Blackorby et al., 1997; Blackorby et al., 1998; Wagner et al., 1994). The literature base that is emerging ties the concept of full-service school to the following areas of need:

- **Prevention**. Full-service schools, because of their emphasis on prevention, hold promise for providing services to children early, when health or behavior problems are first detected. Early intervention has been shown in many cases to reduce the risk of more

Figure 2. Features of Full-Service Schools

There are a variety of ways to describe full-service schools (Dryfoos, 1994), but all have similar features. These include

- **Vision:** The relationship between risk and protective factors present in the lives of children is acknowledged by all participating organizations. Full-service schools present a shared vision about improving long-term conditions for children and families, not simply a goal of providing services or treating a problem.

- **Accessible, child-centered services:** Services are child-centered and family-focused. Full-service schools help children and families solve immediate problems and develop the capacity to avoid future crises. They also provide quality services that are accessible to children and their families.

- **Integrated services, from prevention to intervention:** Full-service schools reflect the entire continuum of services from systems of prevention, to systems of early intervention (early after-onset), to systems of care for the treatment of severe and chronic problems.

- **Collaboration:** At the core of full-service schools are collaborative partnerships and relationships in delivering integrated services. Full-service schools place an emphasis on collaboration between schools, families, and other public and private sector organizations. Integration does not typically mean the merger of service systems but the increased collaboration among them, working toward a common goal. In full-service schools, collaboration is a key process, since input from the community determines what special services will be provided. The assignment of high level administrative personnel to serve as on-site coordinators is a common feature of full-service schools (Vroom, 1997).

- **Culturally competent services:** Full-service schools are committed to responding to the diverse contexts of children and families. At a minimum, participants in such systems understand the ethnic, economic, and social compositions of the students they intend to reach. Appropriate staffing, training, or other operational tasks are provided as a result of the diversity present (Behrman, 1992; Gardner, 1992; Jehl and Kirst, 1992).

- **Shared funding responsibility:** Although the school generally is the practical focal point for coordination of services, funding issues are considered to be a joint endeavor between partners. Schools cultivate extended partnerships so that instruction, family support, and professional resources flow fluidly between home, school, and the community (Salisbury and Dunst, 1997) but it is a rare school that budgets for the services provided. In many cases, it is not an issue of finding new funds, but new ways to use and blend existing funds.

severe problems that result from lack of intervention and treatment (Dwyer, Osher, & Warger, 1998). Full-service schools usually have staff members who recognize the importance of services and work as an integrated team on behalf of all students.

- **Support**. Children with disabilities frequently come from families where there are multiple needs and risk factors arising from life circumstances (Wagner et al., 1993). Given that students with disabilities come disproportionately from families with multiple needs, integrating several services at the school holds particular promise for improving outcomes for students with disabilities. Full-service schools may provide noncurricular services to students that support that total well-being.
- **Integrated services related to special education.** The Individuals with Disabilities Education Act (IDEA) and its 1997 Amendments underscored the importance of viewing special education as a service rather than a place. The trend to bring services to the student can be enhanced through full-service schools. In addition, providing school-based services may reduce the concerns of general education personnel as they work with children with more complex medical or behavioral problems, because they have access to the support of specialists (Sullivan & Sugarman, 1996). The full-service school program benefits students who are disabled because it provides easy access to services that may be needed.

An Established Context in Special Education for Providing Comprehensive Services

The concept of full-service schools underscores the importance of understanding and addressing community resources and supports in the design of systems of support for children, families, and schools. (Salisbury & Dunst, 1997). Providing comprehensive services is not a new concept in special education, as evidenced by the following:

- For more than a century, medical practitioners have worked with school staff to develop procedures for the identification and education of children with special needs. Between 1930 and 1960, schools began institutionalizing support services. Health and mental health professionals—particularly school psychology, school nursing, and school social workers—became district employees and part of school district bureaucracy.

- Federal law, beginning with the Education for all Handicapped Children Act (P.L. 94-142) in 1975 and reaffirmed in IDEA '97, guarantees school-age children with disabilities access to a broad range of special education and related services as part of a free, appropriate public education. To this end, IDEA provides funding support and policy assistance to states. In the IDEA Amendments of 1997, the need for and value of interagency, coordinated service planning and intervention has been reinforced and made more explicit.

- The provision of comprehensive services for young children was highlighted in the 1986 Program for Infants and Toddlers with Disabilities (P.L. 99-457).

- In the area of multiple and severe disabilities, there has been a long-standing need to provide comprehensive services. Because these students often have multiple needs that are interrelated, bringing multiple services to the child and ensuring the central role of families raises many issues for schools—including the need to adopt more integrated and collaborative approaches to service provision (Rainforth & York-Barr, 1997).

- Restructuring initiatives aimed at merging the dual general education and special education systems into a unified system have addressed the provision of comprehensive services (Sailor & Skrtic, 1996). An example is a University of Kansas project that provided school-linked, integrated services to students and their families at neighborhood schools (Smith, Alexander, Skrtic, & Sailor, 1999).

- The call for inclusive schools also challenges general and special education and other support programs (e.g., Title 1, migrant education, bilingual education) to work together and with general education rather than to function as separate, isolated programs (Talley & Schrag, 1999). This initiative, like its interagency special education counterparts, emphasizes the importance of providing comprehensive services and bringing stakeholders together to work toward the common goal of serving children.

Further, the concept of bringing comprehensive services to the child is a familiar one in special education. For example, it has long been established that children with emotional disturbance typically require multiple, comprehensive services. The National Agenda for Children and Youth with Serious Emotional Disturbance (U.S. Department of Education, 1994) called for the coordination among the numerous agencies—education, mental health, health, substance

abuse, welfare, youth services, correctional, and vocational agencies—with services being brought to the child's environment. Schools were considered good places to base an integrated service system for children with emotional disturbance and behavioral problems because

- Children spend considerable time in school, and it is a logical location for service delivery (Eber, Nelson, & Miles, 1997; Osher & Hanley, 1996).
- School systems generally possess well-trained personnel, access to supportive services, and mandated service delivery systems (Dwyer et al., 1998; Eber et al., 1997).
- There is less stigma attached to obtaining a service in schools than to other social service agency locations. Thus, there may be a greater possibility of attaining the participation of both child and family (Koppich & Kirst, 1993).
- The location of services at school sites helps to mitigate other barriers to service delivery, such as time and transportation difficulties (Catron & Weiss, 1994; Osher & Hanley, 1996).

IDEA supports the need to bring comprehensive services to children with its assertion that special education is not a place, but rather a service. The concept and structure of full-service schools fits within the special education agenda of integrating comprehensive services in educational contexts, and of bringing the services to the child.

A Look at Full-Service Schools Serving Students with Disabilities

During the last decade, the U.S. Department of Education's Office of Special Education Programs (OSEP) has funded several projects to investigate the status of school-linked service models, including full-service schools, in serving students with disabilities. The following project descriptions represent an emerging knowledge base on the state of practice.

SRI Looks at Participation of Students with Disabilities in California Statewide Initiative

California's Healthy Start program, a state program designed to integrate services near or at school settings, provided the context for researchers at SRI International to evaluate system issues, service issues, and family outcomes related to providing school-linked services. Authorized by the Healthy Start Support Services for Children Act (SB 620), the initiative provides grants to local education agencies, working in collaboration with other public and private community organizations, to develop or expand existing efforts to provide comprehensive, integrated school-linked services.

No single model of Healthy Start is defined in the state law or regulations. Some local initiatives center around school-based or school-linked health clinics as a way to bring health and mental health services to students. Others emphasize other parental support activities. As such, goals vary widely and include meeting a variety of needs, including health, mental health, family functioning, employment, and basic family household needs.

One example of these programs is a the Healthy Start site operated on the grounds of an elementary school. The school serves an ethnically diverse, highly mobile, and economically impoverished population of 700 children (45 percent Hispanic, 34 percent Asian-American, 14 percent Caucasian, 6 percent African American, and 1 percent Native American). The center houses a mental health clinician's office, 2 dental facilities, 3 medical examination rooms, a medical records room, a dental laboratory, a billing work station, a work station for the neighborhood services worker, a conference room, a waiting room, storage area, two restrooms, and a project

coordinator's office. Originally, services were available only to students and families associated with the school, but later they were made available to the entire community.

The resource center accepts Medi-Cal and private insurance. Uninsured individuals pay on a sliding scale. Many medical, dental, and mental health services are available at the center. Examples are shown in Figure 3.

Figure 3. Examples of Services Provided at One Healthy Start Site

- Diagnosis and treatment of minor illnesses.
- Physical examination.
- Child health and disability prevention examinations.
- Diagnostic tests.
- Vision and hearing screening.
- Basic skill training.
- Counseling, including drug, alcohol, and crisis and emotional counseling.
- Nutrition and health education.
- Emergency first aid services.
- Treatment for chronic illnesses such as asthma, diabetes, and epilepsy.
- Immunizations.
- Laboratory services.
- Prescriptions for medications.
- Diet and weight control programs.
- Prenatal and postnatal care.
- Dental care.
- Physical and occupational therapy.
- Family therapy.
- Individual and group therapy.
- Conflict management.

Acknowledging the fact that almost nothing is known about the involvement of and impacts for students with disabilities, their families, and their teachers, SRI researchers conducted a multi-site analysis of systems, services, and outcomes in school-based programs in California (Blackorby, Newman, & Finnegan, 1997; Blackorby, Newman, & Finnegan, 1998; Lopez, Blackorby, & Newman, 1996; Newman, 1997). Following are selected findings:

- **Involvement of special education.** Only 20 percent of special education teachers had been involved in the planning process for the school-linked services program associated with their schools. Teacher involvement ranged from completing a survey about student problems to helping write the state grant application. Teachers who participated reported that disability issues were given special consideration during the planning and implementation process. About 88 percent of special education teachers had some awareness of the program in their building.

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- **Involvement of special education students.** In 90 percent of the schools, teachers reported that students with disabilities were included in the school-linked services program. However, only an average of 33 percent of students with disabilities were reported to use the services available. Almost 80 percent of all teachers had referred their students and/or families to the program for issues such as behavior problems, parenting skills, medical services, dental services, vision needs, counseling, economic needs (including basic needs such as clothing and furniture) and assessments.

- **Interface between teachers and service staff.** Formal mechanisms were established for providing feedback to the referring special education teacher. Approximately 75 percent of the teachers received feedback, which generally was of an informal and insufficient nature. A little over 50 percent of the special education teachers used the expertise of the service staff (e.g., for health issues related to student use of medication, attendance issues, and concerns about child abuse). Only 41 percent of special teachers reported service staff participation in IEP meetings.

- **Implementation issues.** Most special education teachers reported that there were few differences between referrals for students with disabilities and students in the general population. The barriers to participation were similar for all students, and included unresponsive parents, limited transportation (as in the case of after-school programs), and limited available services (especially case management).

- **Impact.** An overwhelming majority (90%) of special education teachers reported that students with disabilities benefited from access to various services. One-third of the teachers believed that students' transitions out of special education resulted from their participation in the services. Over two-thirds believed that more services were needed, with counseling being the need most often cited. Two-thirds of the teachers indicated a willingness to give up other resources to be able to continue the school-linked academic program. About 40 percent of the special education teachers indicated that their interactions with families increased as a result of the service program.

Overall, researchers concluded that the findings presented a picture of special education teachers as being linked to their schools' school-linked services programs. They stressed the importance of locating the integrated services program on school grounds, and those teachers who were affiliated with school-based programs reported being more closely linked to the program and program staff, being better informed about the offerings, being involved in the planning, collaborating to a greater extent with service staff (e.g., attendance at IEP meetings, more feedback from referrals), having more favorable views of the impact of the program on students, and being willing to give up resources to keep the program funded.

An overwhelming majority (90%) of special education teachers reported that students with disabilities benefited from access to various services.

Researchers also interviewed families of children with disabilities regarding their involvement and satisfaction levels with the school-linked program at their schools. Families of special education students were less likely to go to the school center than families of general education students. Of those families who had received services, the majority found the services to be easily accessible and of high quality.

Based on their work, researchers offered the following recommendations for research:

- Future researchers must recognize that the systems involved are complex. Researchers need flexibility in designing studies that take into account the complex issues involved in integrating services and recognize that it is an evolutionary process.
- Future researchers must examine the difference between macro-level objectives of school-linked services and micro-level services provided to individuals and families in a community. For example, desired outcomes in requests for proposals/grants are often described in terms of changing the statistics in the community (e.g., reducing teen pregnancy, crime, and drop-out rates). Yet

services tend to focus on an individual or family's needs (e.g., dental cleaning, housing assistance, parenting classes).

- When evaluating a successful school-linked services system, it will be difficult for researchers to disentangle the role of one agency or organization because the collaboration between partners and integration of services is far reaching.

Researchers also offered the following recommendations for practice:

- School-linked services models must be viewed as works in progress.
- The following steps must occur before integration can take place: (1) staff of the different community agencies or organizations must open lines of communication; (2) staff of the agencies must conduct a needs assessment to determine the type of services to be offered; and (3) staff of the agencies and organizations must resolve differences in procedures, ideology, and structure.
- To ensure that the special education population is served, students with disabilities must be targeted by school-linked services sites.
- Ongoing review of records and needs assessments must be conducted to ensure that appropriate services are being provided.
- School-linked services sites must find ways to reach all limited English populations and the families of students with disabilities.

University of Maryland Evaluates Linkages to Learning

In 1995, researchers Nathan Fox, Peter Leone, Ken Rubin, and Jennifer Oppenheim at the University of Maryland received funding to replicate and evaluate Linkages to Learning, a model for the delivery of school-based mental health, health, and social services (Fox, Leone, Rubin, Oppenheim, Miller, & Friedman, 1999). The model was designed to provide prevention and early intervention services to children at risk for developing emotional and behavior disorders.

The Linkages to Learning model was developed as the result of a 1991 resolution calling for increased attention to the mental health and social service needs of at-risk children and their families (Leone, Lane, Arllen, & Peter, 1996). The resolution called for services to be both school-based and collaborative. A partnership developed

between the school district, county department of health and human services, and a number of private agencies serving children and families. The partners in this initiative set as their goal the reduction of social, emotional, and somatic health problems that interfere with children's abilities to succeed in school, at home, and in the community.

The school and the community are involved in initial and ongoing needs assessments to determine the needs that must be addressed if children are to succeed. The core services offered are found in Figure 4.

Researchers selected an elementary school site for replication. The school served children in kindergarten through fifth grade, with both Head Start and day care programs on-site. Two self-contained special education classrooms were located in the building. The stu-

Figure 4. Linkages to Learning Core Services

Mental Health Services	Social Services	Educational Support	Health Services
• Mental health assessments. • Individual child, parent, and family counseling. • Consultation with school staff and other agencies. • Prevention, early intervention, and treatment groups for children. • Support groups for parents. • In-service training for teachers.	• Family needs assessments. • Assistance obtaining such daily living requirements as clothing/furniture, food, and housing. • Assistance with legal/immigration, medical/dental, and employment needs. • Translation and transportation assistance. • Assistance accessing day care, summer camps, and school system resources. • After-school and evening recreation workshops. • Acculturation workshops.	• Academic tutoring for students. • SAT preparation. • Mentoring. • Adult education classes (e.g., ESOL, literacy).	• Routine school health services (including first aid and emergency care for sick and injured students). • Medication and treatment administration. • Hearing and vision screening. • Referral and case management for children with physical and medical issues. • Health counseling and health education. • Assistance for parents to access health care in the community.

dent body is culturally diverse, representing over 40 nations and 10 languages. Roughly 75 percent of parents are recent immigrants from Central America, Southeast Asia, Africa, and the Caribbean. The ethnic composition of the student population was 55 percent Hispanic, 27 percent African American, 18 percent Asian American, and 1 percent Caucasian. More than 90 percent of the students were eligible for free and reduced price meals.

A series of repeated measures analyses of variance was completed on data collected from three different sources: primary caregivers, teachers, and children. Analyses compared differences in the average scores between children in the target school and control school, and differences among children in the target school who did or did not receive services through the program. Key findings for children and their families in the target school are shown in Figure 5.

FIGURE 5. Key Findings

- Classroom teachers reported a positive effect on children's behavior over time.
- Children who needed services most were the ones who received them.
- Children reported significantly higher emotional distress levels at baseline than children in the control school. Three years later, distress scores for children in the experimental school were lower than those of children in the control group.
- Children receiving educational services improved significantly more on tests of mathematic achievement.
- Parents of students in the target school reported a significant decrease of children's negative behaviors over 3 years.
- Parents reported being less depressed over time, while those at the control school remained unchanged.
- Parents reported a significant increase in family cohesion over time.
- Parents who participated in the program made the greatest gains in terms of consistency in parenting practices.

University of Miami Looks at the Relationship of Full-Service Schools To Prevention of Serious Emotional Disturbance

The term full-service school was first used in 1991 when the Florida legislature provided funding to support a system of interagency collaboration with mandates to make a comprehensive package of human services available in school buildings. This move represented a policy trend by the state to integrate services near or at school sites. Full-service schools receive funds from the statewide Full Service School (FSS) program.

Researchers Marjorie Montague and Anne Hocutt at the University of Miami looked at full-service schools from the perspective of prevention of the development of emotional disturbance. They studied two full-service schools in urban districts in the State of Florida.

One school served predominantly Hispanic children (70 percent) while the other served predominantly African American children (72 percent). Approximately 12 percent of the students in each school were served in special education classes. The schools were selected because they had a large proportion of children with the additional risk factor of poverty and likely eligibility for Medicaid.

Both schools had state-funded clinic buildings on school grounds that housed the service providers. Both schools offered health services; one offered additional services (mental health, legal, dental, child care, and daily living assistance such as clothing and rent support). Some mental health (counseling, individual and group therapy, case management) services were not co-located on school grounds.

An important focus of the study was a qualitative investigation of the facilitators and barriers to service access and utilization with the full-service school approach for children at risk for emotional disturbance. Overall, locating the services on school grounds resulted in greater access and utilization. School level facilitators included

- **Coordination**. The program is coordinated with the general school program. The coordinator is a fully participating member of the school's Home School Services Team (which is a variation of a child study team). Referrals for all types of problems go through this team, regardless of whether a referred child may or may not be eligible for special education services. The coordinator and team link the full-service school program to the general school program.

Facilitiators to Service Access

- *Coordination with the school program*
- *Communitty involvement*
- *Building administrator support*
- *Cultural sensitivity*

- **Community involvement**. There are monthly meetings of school personnel, families, and community providers. Community members include representatives from organizations that do not provide services on school grounds (e.g., Boys and Girls Clubs, Police Athletic League, Housing Authority). Community issues are discussed, and schoolwide strategies are developed.
- **Building administrator support.** The principal supports the full-service program by developing creative use of funds (e.g., use of Title 1 monies to pay for coordinator), organizing community resources, and demonstrating commitment to the program.
- **Cultural sensitivity.** Educational and other services at the schools are provided in a culturally appropriate manner. Service providers represent the cultural and linguistic backgrounds of the children served.

However, the lack of funding for services required by students became a barrier to carrying out the prevention goal. For many students with serious risk factors, it was determined that case management and therapeutic services were required, but funding was inadequate to provide them. A summary of key findings related to this issue follow (Hocutt, Montague, & McKinney, 2000):

Barriers to Prevention

- *Medicaid coverage changes*
- *Low Medicaid enrollment*
- *Medicaid eligibility requirements*
- *Low enrollment in services*
- *Limits by private providers*

- **Use of Medicaid for funding services.** The State of Florida made changes in the application of managed care to Medicaid that partially affected the delivery of therapeutic or case management services. The changes limited the number of group and individual therapy sessions and the number of contacts between families and professionals. In addition, there were reductions in the amount that could be reimbursed for case management services. There was virtually no impact of these changes in one school, partly because none of the Medicaid-eligible target children who were referred for these services were enrolled in Medicaid. In the other school, the one Medicaid-eligible child was referred to a private therapist, and the noneligible children received mental health services from university interns. Of great concern, however, were the paperwork requirements of Medicaid. In one school, the case manager was fired for failure to file adequate paperwork.
- **Medicaid eligibility.** Medicaid eligibility requirements were seen as a serious barrier to prevention services. To qualify for Medicaid, students had to meet strict criteria for being emotionally disturbed (e.g., the presence of a serious emotional disturbance as indicated by a defined mental disorder and placement/potential placement in a residential institution)—which defeated the purpose of prevention. Thus, case management services were directed toward those children with the most severe problems, rather than toward identified high risk children.

- **Low enrollment.** In one school, the mental health therapist ended the partnership on the basis that not enough children were being served to justify the salary of the mental health therapist.
- **Limitations by private providers.** Private mental health providers in full-service programs in Florida will provide services only to children who are enrolled in Medicaid. Yet Medicaid officials estimate that 80 percent to 90 percent of children who are eligible to participate in Medicaid have not enrolled, thereby limiting services. Researchers found that even though an effort was made at multiple levels to encourage families to apply for Medicaid, many refused. Reasons given for refusal included being in the country illegally, not speaking English, lack of knowledge about the program, and a general distrust of the system.

In summary, researchers concluded that, given present regulatory requirements, Medicaid and managed care were not viable funding sources in the prevention of the development of serious mental health problems. By eligibility requirements focusing on those with serious impairments, limiting delivery of other services, and decreasing contacts between providers and families, managed care was not a viable financial structure for supporting prevention of the development of emotional disturbance.

Implications for Policy and Practice

Full-service schools hold promise for addressing the needs of children in special education in the following ways:

- Preventing problems from becoming more serious and/or being referred to more intensive support programs.
- Providing early intervention.
- Supporting students with multiple risk factors in accessible locations.
- Providing comprehensive intervention support in school settings.

The concept of full-service schools fits with the trend in special education to form interagency and family collaborations and to integrate comprehensive services into the student's educational program.

While it is too early to tell if full-service schools will prove beneficial in addressing the needs faced by children with disabilities and their families, the theory suggests the potential for improving their educational results. More research is needed to explore specific features of how students with disabilities may be served in full-service school

models. In addition, research is needed that addresses the variety of implementation issues (e.g., funding, forming collaborative partnerships, eligibility for services, and interfacing classroom staff with service providers) that affect delivery of services.

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